I. Policy Summary
California Health and Safety Code Section 123110 provides patients with rights to inspect and receive copies of their medical records. California Evidence Code Section 1563 and California Code of Civil Procedure Section 2020 provide direction on allowable reasonable costs for providing this service. The Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) Section 164.524 also grants patients’ rights to access their “designated record set”.

II. Definitions
Designated Record Set (DRS) is a group of records that includes Protected Health Information (PHI) and is maintained, collected, used or disseminated by or for a covered entity for each individual that receives care from a covered individual or institution and is:

- The medical records and billing records about individuals maintained by or for a covered health care provider (can be in a business associates records);
- The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
- Used, in whole or in part, by or for the covered entity to make decisions about individuals.

III. Policy
UCR Health will provide patients with an opportunity to access, inspect and obtain a copy of their Designed Record Set. All requests for such access, inspection or copies must be submitted in writing to University of California Riverside Health Correspondence, Health Information Management Department, 900 University Avenue, Riverside, California 92521.

This policy also applies to UCR Health work force members who are requesting access or copies of their own medical records or that of their family members.
UCR Health will charge a reasonable, cost-based fee for copying (including supplies and labor), postage and the cost of summarizing the information if the individual requests a summary.

UCR Health is not required to provide access to the following:

- psychotherapy notes
- information compiled in anticipation of civil, criminal or administrative action or proceeding
- information not available because of restrictions under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) (laboratory results must be first approved by a physician before providing to the patient)
- oral communications
- requests from a correctional institution, if release of the information would jeopardize the health, safety, security, custody or rehabilitation of the individual, or inmate or an officer or employee of the correctional institution
- the PHI has been created or obtained in the course of research that includes treatment and, in the research consent process, the individual has agreed he or she will not be allowed access to that PHI so long as the research is in progress
- access to information is restricted by the Privacy Act
- the information was obtained from a third party under a promise of confidentiality

While the patient is hospitalized or receiving ambulatory care services, reasonable requests for inspection of the medical record by authorized individuals (e.g. patient, spouse, and guardian) will be granted. The record review will be conducted in the presence of the patient’s health care provider who can answer the patient’s questions, or with a designated administrative staff member. If the patient requests a copy of the medical record the request will be forwarded to the University of California Riverside Health Correspondence, Health Information Management Department, 900 University Avenue, Riverside, California 92521.

As long as the individual is allowed a review of the denial, UCR Health may deny access to the designated record set in the following circumstances:

- A licensed health care professional has determined that access could endanger the life of the individual or another person.
- The requested information references another person (except a health care provider) and a licensed health care professional has determined that access is reasonably likely to cause substantial harm to the other person.
- The request is made by an individual’s personal representative and a licensed health care professional has determined that access is likely to cause substantial harm to the individual or another person.

UCR Health can only deny access to that portion of the designated record set
described in a, b, or c above. To the extent possible, the individual must have access to all other information.

If UCR Health denies access, UCR Health must provide a written denial to the individual, and the written denial must:

- Be in plain language,
- Contain the basis for the denial,
- Include a description of how the individual may complain to UCR Health, and
- Include the name or title, telephone number of the Compliance and Privacy Officer designated to receive complaints.

If access is denied and the individual requests a review of the denial, UCR Health will designate a licensed health care professional, who did not participate in the denial of the access decision, to act as a reviewing official. Within a reasonable time period, the reviewing official must decide, based on the standards, whether to deny access and provide the individual with a written determination.

Requests for access to records, copies of records and records of denial of access will be maintained by the Health Information Management Department.

IV. Responsibilities: N/A

V. Procedures:

Roles and Process of Submitting and Fulfilling Information Requests

A. Patient/Personal Representative

1. Submit a written request to inspect or receive copies of medical information via a completed Request for Access Form. (A written letter including all information specified in the Request for Access is acceptable.)

2. All requests should be directed to: University of California Riverside Health Correspondence, Health Information Management Department, 900 University Avenue, Riverside, California 92521.

B. Nursing/Medical Assistant

4. If the patient or the patient’s representative requests to inspect the patient’s record while the patient is hospitalized or receiving ambulatory services, notify the attending physician of the individual’s request to review the record.

5. Record review must be conducted in the presence of the attending or resident physician or nurse, in order that the reviewer’s questions may be answered and the integrity of the record protected. The record may also be reviewed in the presence of a designated administrator.

C. Medical Correspondence
6. Upon receipt of the written completed Request for Access, obtain records as requested.
   a. Requests to access or inspect the record must be granted or denied within 5 days of the request
   b. **Psychiatric Unit**: Obtain attending physician’s approval and document the record.

7. Review records to determine if access is requested for mental health records.
   a. If the Request for Access is for mental health records, forward record and Request for Access to attending psychiatrist to obtain written approval for access.
   b. If the physician indicates that information harmful to the patient is in the record, contact the Health Information Management Department.
   c. Verify signature of patient on request.

8. Verification of Identity must occur prior to any disclosure permitted by this policy.
   a. Verify Patient/personal representative identity before providing access. Verification by means of photo ID, such as a driver’s license, CA state identity card, passport or other forms of picture identification.
   b. Before mailing, verify address of patient or personal representative to ensure address matches the address in the registration system.
      1. If not confirm with patient by calling patient to verify the address.
      2. Notify registration department of address correction.
   c. If the records are those of a minor, verify the parent is the parent with legal custody of the child.
   d. If the patient request copies of their records electronically, and the system is capable of providing an electronic copy (for example a CD of radiology images), the data must be provided electronically, encrypted with a password.

   **D. Attending Psychiatrist, Medical Correspondence**

   9. Attending Psychiatrist complete check boxes on Request for Access to indicate approval or disapproval and reason for disapproval if that is the decision and return to Medical Correspondence.

   10. If attending psychiatrist does not approve request for access, Medical Correspondence Office complete a written denial of request and return to patient/patient’s representative.

   **E. Medical Correspondence**

   11. Process request for copies or schedule appointment for patient to review records. If request is to “inspect” records make arrangements for inspection to occur in presence of staff to assure integrity of record. Access must be granted within 5 days from date of request.
12. Fees for copies will be in accordance with fee schedule (Attachment A) in accordance with state guidelines.

13. Copies of the medical records must be provided, or a written denial within 15 days.

14. Access to other elements of the designated record set (DRS) located or maintained off-site and not readily accessible must be completed within 30 days.
   a. A one-time delay of no more than 30 days is allowed but the individual must be provided with a written reason for the one-time delay and a specific date when the Medical Center will take action on the request.

15. Records of minors
   a. Certain services may be obtained by a minor aged 12 or older.
   b. If the parent or personal representative is requesting a copy of the record, the minor patient must authorize the disclosure.
   c. Emancipated minors - Certain emancipated minors have control over their medical information and the parent cannot authorize access or disclosure to this information.

VI. Forms/Instruction:
Attachment A

VII. Contacts:

<table>
<thead>
<tr>
<th>Unit</th>
<th>Title</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>Compliance and Privacy Officer</td>
<td>(951) 827-4672</td>
</tr>
<tr>
<td>Compliance</td>
<td>Privacy Analyst</td>
<td>(951) 827-7672</td>
</tr>
</tbody>
</table>

VIII. Related Information: N/A

IX. Frequently Asked Questions: N/A

X. Revision History: N/A

Approval(s):

James R. Herron
Compliance and Privacy Officer
School of Medicine
Attachment A

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Patient Address:</td>
<td>Street</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
</tr>
</tbody>
</table>

I authorize UCR Health to release health information to:

Name of person or facility to receive health information

Specify name/title of person to receive health information, if known

Street Address, City, State, Zip Code

Phone number

INFORMATION TO BE RELEASED

- [ ] Discharge Summary
- [ ] Laboratory Reports
- [ ] Emergency Medicine Reports
- [ ] Billing Statements
- [ ] Dental Records
- [ ] History & Physical Exams
- [ ] Pathology Reports
- [ ] Operative Reports
- [ ] Diagnostic Imaging Reports
- [ ] EKG
- [ ] Radiology Reports
- [ ] Consultations
- [ ] Progress Notes
- [ ] Outpatient Clinic Records
- [ ] Vaccinations/Immunizations
- [ ] Other

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

SPECIFIC AUTHORIZATIONS

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- [ ] I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
- [ ] I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, et. seq.)
- [ ] I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code §120980(g)).
- [ ] I specifically authorize the release of genetic testing information (Health and Safety Code 124980(j)).
Nombre del Paciente:______________________________
Fecha de Nacimiento:______________________________
Dirección del Paciente:______________________________
Calle
Ciudad Estado Código Postal
Número de Teléfono:______________________________

Autorizo al UCR Health para proporcionar/entregar información sobre la salud a:
______________________________________________________________________________________________
Nombre de la persona o institución que recibirá la información sobre la salud

Especificar nombre/título de la persona que recibirá la información sobre la salud, si se conoce
______________________________________________________________________________________________
Dirección (Calle, ciudad, estado, código postal)

Número de teléfono

INFORMACIÓN A SER ENVIADA

☐ Resumen de alta ☐ Informes de Laboratorio ☐ Informes de Sala de Urgencias
☐ Detalle de facturación ☐ Expedientes Dentales ☐ Antecedentes Clínicos y Exámenes Físicos
☐ Informes de patología ☐ Informes de Operaciones ☐ Exámenes de Diagnóstico por Imágenes
☐ Electrocardiograma ☐ Notas sobre evolución clínica ☐ Informes de Radiológicos
☐ Vínculos/Immunizaciones ☐ Otros
☐ Consultas ☐ Expedientes Clínicos de Atención Ambulatoria

ESPECIFIQUE LA FECHA O PERÍODO DE TIEMPO PARA LA INFORMACIÓN SELECCIONADA ARRIBA

AUTORIZACIONES ESPECÍFICAS

La siguiente información no será proporcionada a menos que usted lo autorice específicamente al marcar el/lo(s) casillero(s) correspondientes que se encuentran debajo:

☐ Autorizo específicamente la entrega de la información correspondiente al diagnóstico o tratamiento de abuso de drogas y alcohol (42 C.F.R. §§2.34 y 2.35).
☐ Autorizo específicamente a entregar información correspondiente al diagnóstico o tratamiento de la salud mental (Welfare and Institutions Code §§5328, et seq.)
☐ Autorizo específicamente la entrega de información sobre las pruebas de VIH/SIDA (Health and Safety Code §120980[g]).
☐ Autorizo específicamente la divulgación de información sobre pruebas genéticas (Health and Safety Code 124980[j]).
THE PURPOSE OF THIS RELEASE IS (check one or more)

☐ Continuity of care or discharge planning
☐ Billing and payment of bill
☐ At the request of the patient/patient representative
☐ Other (state reason) ____________________________

NOTICE

UCRH and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

☐ I understand this authorization is voluntary. Treatment, payment enrollment or eligibility benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan for 3) determining an entity's obligation to pay a claim, or 4) creating health information to provide a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

☐ I may revoke this authorization at any time, provided that I do so in writing and submit it to UCR Health, School of Medicine, 900 University Avenue, Riverside, CA 92521. The revocation will take effect when UCRH receives it, except to the extent that UCRH or others have already relied on it.

☐ I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires: ____________________________ (insert applicable date or event).
If no date is indicated, this authorization will expire 12 months after the date of signing this form.

PERSONAL USE
I understand I will be charged a per page fee for copies produced for my personal use.

Initial________________________

SIGNATURE ____________________________ Date: ____________________________

(Signature of Patient or Patient's Legal Representative)

Time: ______ AM/PM

Printed Name________________________

(If signed by someone other than the patient, state your legal Relationship to the patient/authority)

Witness or Translator________________________

Mail form with original signature to:
UCR Health
School of Medicine
900 University Avenue
Riverside, CA 92521
1-855-827-CLINIC (2546)
EL PROPÓSITO DE LA ENTREGA DEL EXPEDIENTE MÉDICO

(marque uno o más)

☐ Continuidad de la atención médica o planificación de dada de alta
☐ Facturación y pago de los servicios
☐ Ante la solicitud del paciente/representante del paciente
☐ Otros (declare la razón) __________________________

AVISOS

El UCRH y muchas otras organizaciones y personas tales como médicos, hospitales y planes de atención médica tienen el mandato legal de mantener su información médica bajo confidencialidad. Si usted ha autorizado la entrega de su información sobre la salud a alguien que no está legalmente obligado a mantenerla bajo confidencialidad, la misma ya no estará resguardada por las leyes federales y estatales de confidencialidad.

MIS DERECHOS

☐ Comprendo que esta autorización es voluntaria. El tratamiento, el pago por inscripción y la elegibilidad para recibir beneficios no se puede condicionar a la firma de esta autorización excepto que la misma esté destinada a: 1) realizar un tratamiento vinculado con una investigación, 2) obtener información relacionada con la elegibilidad o inscripción a un plan de atención médica, 3) determinar la obligación de una entidad de pagar una demanda, o 4) generar información sobre la salud para suministrarla a una tercera parte. Sin embargo, bajo ninguna circunstancia se me solicita autorizar la entrega de expedientes sobre la salud mental.

☐ Puedo revocar esta autorización en cualquier momento, bajo condición de realizarlo por escrito y presentarla ante UCR Health, School of Medicine, 900 University Avenue, Riverside, CA 92521. La revocación entrará en vigor cuando UCRH la reciba, excepto en la medida que UCRH y otros ya se hayan sujetado a la misma.

☐ Tengo derecho a recibir una copia de esta Autorización.

VENCIMIENTO DE LA AUTORIZACIÓN

A menos que se la revoque en otras circunstancias, esta autorización vence ______________________
(completar con la fecha o hecho pertinente). En caso de no indicarse una fecha, esta autorización vencera a los 12 meses de la firma del presente formulario.

USO PERSONAL

Entiendo que se me cobrará una tarifa por página por cada copia que solicite para mi uso personal.

Inicial __________________________

FIRMA __________________________

(Firma del Paciente o Representante Legal del paciente)

Fecha: __________________________
Hora: _______ AM / PM

Nombre en Letra de Molde __________________________

(Si la firma no corresponde al paciente, declare su relación legal con el paciente/autorización)

______________________________

Testigo o traductor __________________________

Envíe por correo el formulario con la firma original a: UCR Health School of Medicine 900 University Avenue Riverside, CA 92521 1-855-827-CLINIC (2546)